STEP EIGHT

SUPPLEMENTAL SECTION

Sample Survey for All Departments

Subject: Confidentiality
The Privacy Act

1.	YES NO	Can you keep records of patients that they don't know about?
2.	YES NO	Patients have a right to know what information is being kept about them.
3.	YES NO	Patients have a right to know how the information that is being kept about them is being used.
4.	YES NO	Patients have a right to access the information about them that has been collected.
5.	YES NO	Patients have a right to correct or amend factual inaccuracies in their records.
6.	YES NO	Patient information generally may be disclosed without the patients' authorization for purposes other than for which it was collected.
7.	YES NO	Patient's relatives, friends, and government leaders are implicitly authorized to access patient information because of their beneficial relationship.
8.	YES NO	Parents can access their minor children's health records if the parents consent to the care.

Sample Survey for Individual Departments

SUBJECT: CONTRACT HEALTH OR BUSINESS DEPARTMENT QUESTIONS

If you need additional space, please use the back of this paper.

ADMISSIONS

1. What information is currently being given to patients before they are sent out for contract health care or before they enter the hospital? When, by whom and in what format is this information being given?

2. What staff members have contact with the patient during admission that might present relevant patient education?

3. Do you see a role for admissions in the patient education process? What problems would you anticipate?

4. Patients should receive instructions about any follow-up care needed and how to obtain that care through Contract Health. What is the process for follow-up referrals to outside Providers and/or Special Clinics?

Sample Survey for Individual Departments

SUBJECT: NURSING QUESTIONS: InPatient Outpatient Nursing	**Community/Public Health Nursing** **LPN's, CNA**

1. Where do you provide nursing services? Indicate those that apply:
   ___ Inpatient ___ Public/Community Health Nursing
   ___ Outpatient ___ Other

2. YES NO Does your nursing program provide individual patient education?

3. YES NO Do you have written specific guidelines and/or curriculum for nursing staff to use during individual patient education activities?

4. Which nursing staff members provide individual patient education? Circle those that apply:

   Nurse Educator RN
   Nurse Supervisor LPN
   Public/Community Health Nurse NA
   Clinic Nurse Other: _____
   Specialty Nurse (Diabetes)_____

5. Is patient education documented in the medical record? Yes or No

   If Yes, indicate how often would you estimate patient education is documented in the medical record:

   ___ 10% of the time
   ___ 25% of the time
   ___ 50% of the time
   ___ 75% of the time
   ___ 100% of the time

6. What are perceived barriers to providing patient education to individuals? (Check those that apply)

   ___ Time
   ___ Privacy: No room to provide confidentiality
   ___ Not enough staff
   ___ Minimal teaching aids/resources
   ___ Other: _____

7. YES NO Do you provide patient education in groups?

8. YES NO Do you currently utilize nursing care plans?

9. YES NO If you currently utilize nursing care plans, are they standardized?

9. YES NO Are teaching plans a part of the nursing care plans?

10. What patient education programs have you developed which contain a *written* curriculum targeting specific groups, i.e., diabetes, hypertensives, prenatals, etc.?

___	Diabetes	___	Hypertension	___	STD's
___	Prenatal	___	Tobacco	___	AIDS
___	Birth Control	___	Well Child	___	Cancer
___	Exercise	___	Arthritis	___	A/SA
___	Heart Disease	___	Nutrition	___	Other:

_____
_____

11. YES NO Is a multidisciplinary approach used in providing education? If so, which disciplines are involved? Please list.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please circle the appropriate response:		Disagree				Strongly Agree
12.	Patient Education can improve patient health status.	1	2	3	4	5
13.	Nursing is an important link in the patient education process.	1	2	3	4	5
14.	To be truly effective, patient education should be a planned, comprehensive session provided by specific individuals with the time necessary to do the job correctly.	1	2	3	4	5
15.	Nurses have the responsibility for assuring that patient education is provided.	1	2	3	4	5

Sample Survey for Individual Departments

SUBJECT: MEDICAL RECORDS QUESTIONS

1. What are patients told about the contents of their health records?

   Who tells them? When? How often?

2. What are patients told about the purposes of the contents of their health records?

   Who tells them? When? How often?

3. What are patients told about the disposition of their health records?

   Who tells them? When? How often?

3. What are patients told about the confidentiality of their health records and about whom has access to them?

   Who tells them? When? How often?

4. What are patients told about the release of information from their health records and who has access to them?

   Who tells them? When? How often?

6. What are patients told about their rights to access their health records?

   Who tells them? When? How often?

Additional comments should be written on the back.

Sample Survey of Individual Departments

SUBJECT: Health Education

YES NO 1. Do you think health education should be included in the process of patient education?

YES NO 2. Do you see a role for Health Education in the patient care process?

YES NO 3. Standards suggest that at least 25% (1-2 hours per day) of the Health Educator's time should be spent on patient education and I agree.

YES NO. 4. Patient Education teaching sessions have been developed by this Health Education department.

YES NO 5. I would feel comfortable in providing patient education sessions.

6. *For each of the following where you currently provide group or patient education: Put a one (1) in front of those where you currently provide education; Put a two (2) in front of those where you would like to increase your patient education activities. If you are not involved in any of the following departments or if your Tribe does not have these departments, please put a Zero. (0)*

___WIC/Nutrition
___Well Child Clinic
___Day Care Centers
___Middle/junior schools
___Diabetes
___Substance Abuse
___Parenting Programs
___Other: Please Identify: _____

___ Elder organizations
___ Head Start
___ Elementary Schools
___ High Schools
___ Injury Prevention
___ Cancer Prevention/Screenings
___ State, County, Tribal or local health organizations

7. What problems do you foresee in the provision of patient Education?

_____

_____

7. Please check any of the following that are true concerning patient education and the Health Education Program in your facility.

Answer YES or NO to the following. If it is not applicable, answer with a zero (0).

1.___ Patient Education referrals **are made** to the Health Education Program. If the answer is YES, please answer
the following three questions. If the answer is NO, move to question 2.
___ But, very few health professionals make referrals to the Health Educator for patient education.
___ If referrals are made to Health Education, the referrals are in writing and documented on the patient's chart/record.
___ If referrals are made to Health Education, they are usually verbal.

2.___ Patient Education referrals **are not made** to the Health Education Program.
___ Health professionals do not make referrals to the Health Educator for patient education .
___ It is not our policy to make referrals to Health Education for patient education.
___ My Health Education Program does provide some patient education.
___ My Health Education Program does not provide patient education.
____ I would like to see Health Education provide more patient education.
____ I prefer that the Health Education program continue to provide Community-based programs rather than concentrate on individual or group patient education.

Sample Survey of Individual Departments

SUBJECT: Physicians

Please take a few moments to complete this survey to help the Health Education Committee provide patient education services that meet the needs of our providers and our community.

Who provides patient education for patients in your Clinic? Check all that apply:

___ Doctors ___ Nurses ___ Nutritionist/Dietitian
___ CHR's ___ No One ___ Health Educator
___ Other: Please Specify: _____

Please circle the appropriate response:

		Strongly Disagree				Strongly Agree
1.	Patient Education can improve patient health status.	1	2	3	4	5
2.	Doctors do not have enough time to provide patient education during clinic visits.	1	2	3	4	5
3.	Our Clinic has a simple and effective process in place for me to refer patients for health education.	1	2	3	4	5
4.	Nurses should have primary responsibility for providing patient education.	1	2	3	4	5
5.	Our patient education program provides the scope and quality of services I need for my patients.	1	2	3	4	5

To ascertain the need for developing comprehensive patient education sessions, please rank the following topics in order of their usefulness and importance to you and your patients.

1 = Most useful
9 = Least useful

___ hypertension
___ prenatal care
___ Well Child Care
___ alcohol/substance abuse
___ Diabetes- General info
___ AIDS/STD's
___ cancer prevention (tobacco cessation, PAP's, etc.)
___ Diabetes- nutrition
___ family planning
Other: _____

Please write additional comments or suggestions on reverse.

Thank You.

Sample Survey of Individual Departments

SUBJECT: Nutritionist (to be completed by staff Nutritionist/Dietitian)

1. Approximately what percentage of your time is spent providing patient education?
____ Less than 5% ___ 5-10% ___ 11% -15% ____Over 15%

Of the total percentage you identified above, what proportion is spent on:
a. individual patient education sessions:
____ Less than 25% ____25%- 50% ____50% - 75% _____Over 75%
b. group patient education sessions:
____ Less than 25% ____25%- 50% ____50% - 75% _____Over 75%

1. Do you feel that other staff members/paraprofessionals can play an active role in providing basic nutrition education to patients? ___ YES ___ NO

3. Who at your facility provides patient education on nutrition? (Check all that apply.)
___ Registered Dietitian/Nutritionist ___ Dietetic Technician
___ Nutrition Aides/RN ___ Nursing Staff (RN/LPN's)
___ Medical Providers (MD's,PA's FNP's) ___ Dental Staff
___ WIC ___ Other: Please Identify:

2. Have nutrition-oriented lesson plans/teaching sessions been developed or purchased for use in providing patient education? ___ YES ___ NO

If yes, in what topic areas? (Check all that apply.)

___Diabetes and Nutrition ___Fat/Cholesterol
___Child Nutrition ___Sodium
___Infant Nutrition ___Weight Control
___Prenatal Nutrition ___"Basic" Nutrition
___Other: Please Specify: _____

3. Do Nutrition Program staff at your facility provide patient education on any non-nutrition related subjects? ___ YES ___NO
If yes, in what topic areas? (Check all that apply)
___Fitness/Exercise ___Diabetes (Non-Nutrition related)
___Smoking Cessation ___Other: Please Specify:

6. How do you feel patient education could be better coordinated between the different departments/ programs within your facility?

_____

_____

Sample Survey of Individual Departments

SUBJECT: Dental (to be completed by Dental staff)

1. Approximately what percentage of dental staff time is involved in oral health promotion and patient education?
   ___ Less than 5% ___ 5%-10% ___ 11%-15% ___ Over 15%
   Of the total percentage you identified above, what proportion is spent on:
   a. individual patient education sessions:
      __Less than 25% __25%-50% __50%-75% __ Over 75%
   b. group oral health promotion/education sessions:
      __Less than 25% __25%-50% __50%-75% __ Over 75%
2. What types of health professionals are available to your facility for consultation/referrals/joint projects for oral health education/ promotion? Check all that apply.

___ Physician	___ Health Educator	___ PA
___ Nutritionist	___ Social Worker	___ CHR
___ Sanitarian	___ Public Health Nurse	___ RN

   ___ Other: Please Specify: _____

3. Do you use a process or instrument to assess individual patient education needs?
   ___ YES ___ NO

4. Does your health facility have a designated Patient Education Coordinator? Answer Yes or No Below: If the answer is No, please go to question #5.
   ___ YES our facility has a designated patient education Coordinator.
   ___ The dental program finds the service valuable
   ___ but does not use the services

5. Does your health facility have a designated patient education Coordinator? Answer Yes or No:
   ___ NO, our facility does not have a designated PFCE Coordinator.
   ___ The dental program would utilize such services if available
   ___ probably would not utilize the services

6. Is the dental program involved with any of the following programs or agencies?

   Put a one (1) in front of those presently involved with; Put a two (2) in front of those that you would like to increase your involvement with.

___WIC/Nutrition	___ Elder organizations
___Well Child Clinic	___ Head Start
___Day Care Centers	___ Elementary Schools
___Middle/junior schools	___ High Schools
___Diabetes	___ Injury Prevention
___Substance Abuse	___ Cancer Prevention/ Screenings
___Parenting Programs	___ State, County, Tribal or local health organizations

   ___Other: Please Identify: _____

7. Do you have adequate oral health education materials on the following topic areas? Please write a Yes or No.

___Diabetes	___ Oral hygiene
___Sealants	___ BBTD
___Oral Health for Special Needs Patients	___ Fluorides/fluoridation
___Pregnancy and oral health	___ Nutrition
___Children's oral health	___ Periodontal disease
___ Tobacco and Oral health	___ Other:

Please list those topic areas where you think you have adequate health education materials:

_____
_____
_____

7. How important are the following items in the oral health promotion/ education materials you use:

Number choices from (1) to (7), with 1 being the most important.

___	AI/AN Specific	___	reading level
___	overall visual appeal	___	pictures/artwork
___	humor	___	scientific accuracy
___	limited to 1-2 main messages		

8. How do you feel patient education could be better coordinated between the different departments/programs within your facility?

_____
_____

Sample Survey for Individual Departments

SUBJECT: PHARMACY

Pharmacy Education Assessment Tool

1. All patients receiving medicine will receive education counseling about:

   A. Use of drug - how to take it. Yes No
   B. Any expected side effect of drug. Yes No
   C. Storage of Drug Yes No
   D. Any other drug or other related potential reaction. Yes No

2. All patients receiving any special apparatus or dispensing packet:

   A. Will be given explicit directions. Yes No
   B. Will be asked to demonstrate that they understand and know not to use. Yes No

3. Any cautionary label which serves as a reminder to patients to abide by, will be attached to the medicine container. Yes No

4. Any special handout pamphlet pertaining to drug use or caution, will be shared with the patient. Yes No

5. Documentation will be entered into the medical chart denoting counsel/education performed and pharmacist will sign chart. Yes No

6. Does pharmacy participate in special projects, HPDP activities, Clinics and/or other aspects of health care sponsored by the Hospital/Clinic? (Other than the dispensing of medication.) Yes No

   Examples: _____

   _____

7. Pharmacy would welcome the opportunity to participate all patient education endeavors. Yes No

Sample Survey for Individual Departments

SUBJECT: CHR'S

1. How can Community Health Representatives assist in the patient education process?
Please check any of the following that apply:
_____ Ensuring that patient education is provided to the patient and his/her family.
_____ Assist in follow-up for No Shows or DNKA's.
_____ Provide period up-dates to staff on client's specific conditions, etc.
_____ Patients shall receive instructions about any follow-up care needed and how to obtain that care.

2. Who is responsible for providing follow-up care information to patients? (This may involve more than one department/discipline.)
_____

3. How could the provision of follow-up care information be documented?
_____

3. Where in the patient's health record/chart will follow-up care instructions be documented and by whom?
_____

6. YES NO Information about discharge instructions given to the patient is provided to those CHR's responsible for the continuing care of patient.

7. YES NO CHR's should have patient education teaching/lesson plans.

8. Who is responsible for providing copies of discharge instructions to patient families?
_____

to physicians and other individuals providers?
_____

to organizations/facilities responsible for continuing care?
_____

b. How could the provision of this information to the client by the CHR's be documented in the patient's health record/chart?
_____

c. Where in the patient's health record/chart will the provision of this information be documented?
_____

and by whom?
_____

Sample Survey for Individual Departments

SUBJECT: Alcohol and Substance Abuse

Within the A/SA Program, who provides health/patient education for patients in your Program?

Check all that apply:

___ Doctors ___ Nurses ___ Nutritionist/Dietitian
___ CHR's ___ No One ___ Health Educator
___ A/SA staff ___ I am not aware of patient/health education in the A/SA Program
Other: Please Specify: _____

Please circle the appropriate response:

		Strongly Disagree				Strongly Agree
1.	Patient Education can improve patient health status.	1	2	3	4	5
2.	A/SA Counselors do not have enough time to provide patient education during visits.	1	2	3	4	5
3.	A/SA Counselors do not have the expertise to provide patient education during clinic visits.	1	2	3	4	5
4.	Our Clinic has a simple and effective process in place for me to refer A/SA clients for health/patient education.	1	2	3	4	5
5.	A/SA staff should have primary responsibility for providing patient/health education.	1	2	3	4	5
6.	Our patient education program provides the scope and quality of services I need for my A/SA clients	1	2	3	4	5
7.	Our A/SA Program works closely with the Mental Health Program.	1	2	3	4	5
8.	Our A/SA Program works closely with all disciplines in our in our Hospital/Clinic.	1	2	3	4	5
9.	I think we do a good job of covering the educational needs of our clients.	1	2	3	4	5

Please check which of the following topics are useful and important to you and your A/SA clients.

___ hypertension
___ prenatal care
___ Well Child Care
___ Nutrition
___ family planning
___ Mental Health
___ AIDS/STD's
___ cancer prevention (tobacco cessation, PAPs, etc.)
___ Gay/lesbian issues
___ FAS
___ Diabetes- General info
___ TB

10. How often do you make patient education referrals to Health Education or other patient educators?
_____ Seldom _____ Sometimes _____ Frequently

11. If you have checked seldom or sometimes, select the most common reason:
_____ Access to patient education services is inconvenient
_____ Patient Education services are not in the same building
_____ Never thought of it
_____ The current Patient education given by our Program is sufficient.
_____ Not clear as to the duties of other health providers
_____ Other: _____

12. What would it take to enhance coordination with patient education services?
_____

_____

Sample Survey of Individual Departments

SUBJECT: Business Office

For additional space please use the back of this page.

1. What information is given to patients at the Patient Registration Process? Who is giving this information? How often is this information given?

2. What information is given to patients during the Admission process? Who is giving the information?

3. What information is given to patients by the Patient Benefits Coordination regarding their role? How often is this information given?

3. What information is given to patients by the Patient Accounting Technicians regarding billing Third Party Insurance Carriers?

4. What information is given to patients as to why the Business Office asks the questions they do? How often? Who informs the patients of this information?

5. Do you think the Business Office has a role in providing Patient Education? Briefly explain your answer.

Sample Survey of Individual Departments

SUBJECT: Mental Health

1. How are you documenting the mental health services you provide? Check which applies.
   _____ PCC
   _____ Independent Mental Health records

2. What type of patient education and/or psycho educational counseling are you providing? Check those that apply.
   _____ Bibliotherapy or Self-Help
   _____ Wellness
   _____ Skills (Parenting techniques, stress management)
   _____ Family Information (care of patients with Alzheimer's and MI, etc.)
   _____ Topic oriented groups
   _____ Medication management
   _____ Informational handouts (Depression, FAS/FAE, CA/N, etc.)
   _____ Resource Information (related services)
   _____ Other: _____

3. How often do you make patient education referrals to Health Education or other educators?
   _____ Seldom _____ Sometimes _____ Frequently

3a. If you have checked seldom, select the most common reason:
   _____ Access to patient education services is inconvenient
   _____ Patient Education services are not in the same building
   _____ Never thought of it
   _____ The current Patient education given by our Program is sufficient.
   _____ Patient education given is integral part of Mental Health therapy.
   _____ Not clear as to the duties of other health providers
   _____ Other: _____

4. What would it take to enhance coordination with patient education services? (Write your anwer on the back)

Resource Collection on a Budget: Establishing a Patient Education Library

Introduction
Few health providers will argue against the importance of patient education.

The development of a patient education resource library should be and can be developed at all sites - regardless of clinic or hospital size, or staffing. Sites with total Contract Health Services should also develop a Patient Education File/Library. Too often Contract Health Service sites assume that the private physician or provider is providing adequate patient education services. The truth is private providers usually offer random patient education services -- incorrectly assuming that the Indian Clinic or Hospital has educated the patient before they came to their office or assuming that someone at the Indian Clinic or Hospital will talk to them after they leave their private office.

There are many commonly voiced concerns by the Health providers prior to commencement of a patient education library project -- most concerns and objections will center on money. This section of the Manual provides some guidelines to meet the challenge of funding.

Common concerns of the staff:

- *"Where will we do patient education? There is no patient education "room," - therefore, there is no "convenient area" in which to provide patient education."*
- The Clinic or Hospital does not have an empty room or unused area near the examining rooms - *"We will need more space."*
- *"There is no place for privacy or confidentiality."*
- There is no audio-visual equipment (such as VCR's) or projectors or staff requests expensive new equipment. *"No audio-visual equipment."*
- Staff estimates that they will need several thousand dollars to purchase printed patient education materials and videos. *"Money!"*
- Staff points out that printed pamphlets, brochures and other information is conveniently placed in the waiting area for patients to freely take. Perhaps a video is also shown on the waiting room TV. *"Isn't this patient education?"*
- And last, but not least, in importance is the often heard refrain that there are *no "Indian -specific "* materials available.

Often the barrier to the provision of comprehensive patient education is not rooms, pamphlets nor money. The largest barrier to the provision of patient education is time. Commitment to the importance of patient education, the management of time through the development of policies and procedures to govern patient education and the organizational structure of the health clinic or hospital are just some of the obstacles to overcome in order for patient education to become a reality.

Administrators' commitment to patient education will most assuredly be tested.

Purpose
Patient Education is a planned learning experience, which can be achieved by using a combination of three methods that influence patient knowledge and health behavior:

- teaching and demonstrating,
- counseling, and
- behavior modification.

This process demands time and effort that can be difficult to manage in a busy hospital or clinic. Many health professionals attempt to shorten the teaching process by providing written materials to patients so they can educate themselves on their own time. Although printed and non-printed materials are important tangible supplements, they should not be construed as a substitute for planned education.

Comprehensive patient education is more than handing a prenatal client a plastic bag "stuffed" with various printed pamphlets and materials on pregnancy and childbirth.

The abundance and variety of educational materials can be overwhelming. It is not possible to collect, organize and store ***all*** teaching resources. A patient education library or file for a hospital or clinic must contain those materials that will yield the greatest benefit for the teacher and learner alike. In addition, without a financial grant or unlimited financial resources there is a need to be fiscally responsible.

Education resource collections can be developed to serve different purposes. One such purpose is to assemble a limited variety of education materials about a prevalent health problem. For example, a clinic that has large numbers of hypertensive patients may choose to focus on resources dealing with the nature, diagnosis, and therapy of hypertension. The materials may include video tapes, pamphlets, and audio tapes.

Another purpose is to assemble a comprehensive set of all available materials dealing with a particular subject that is common to Native Americans - such as diabetes.

It can be frustrating to health professionals and patients alike when there is a scarcity of information on file concerning a patient's medical problem. The physician or Health Provider can consult a medical journal or personal files -- where and what is available to the patient to help them understand their condition? This may be another reason for develop resource collection -- to provide ready access to educational materials during patient visits. This allows the practitioner to take advantage of the "teachable moment" and the opportunity to link clinical and educational information. Learning impact is lost if the materials are not immediately accessible. In addition, having multiple and varied resources on hand avoids duplication of the practitioner's time and effort in developing educational media.

Process

A resource collection can be solicited, collected, organized and sorted more easily if the process boundaries are specific enough. Goals and objectives should reflect the intent, extent and specificity of purpose, and a time frame defined for resource collection and library completion.

Unfortunately, there is not an abundance of Indian-specific educational materials available. Studies have shown that Native Americans react more favorably when educational materials such as videos, posters, or pamphlets include Native Americans in the content.

An individual health professional can establish a resource collection, but the team approach provides benefits from collective expertise, discussion, and task delegation. A higher quality product is often the result. Each team member should have specific duties. Among the staff, for example: who contacts potential contributors, who reads and evaluates the material, who determines the classifications, who is responsible for storing the resources?

Many materials are free and a wealth of materials can be collected from many sources. The common ones include:

- government agencies,
- pharmaceutical companies,
- commercial vendors,
- self-help support organizations,
- non-profit organizations,
- professional peer organizations,
- consumer magazines
- newspapers,
- health publications
- and, physicians and nursing journals,

There are many excellent diagrams, illustrations, models, posters, audio and video sources, though most materials are print media. One material source often will lead to others, which then contributes to the beginning of a collection.

Appropriately defining and classifying resource materials is a critical process. Definitions may be arbitrary, and for our purpose, materials are defined as "information," "instruction," and "comprehensive." Classifications may be by author, title, publisher, key word, anatomical organ, disease, procedure, operation, therapy, media type or language. Others may be CPT or ICD codes, NLM or LC classification or listings according to the Index Medicus.

Items should be defined, analyzed, rated, then catalogued. Again, these parameters can be arbitrary, but must be consistent throughout.

The reading level should be determined by applying readability formulas. Most computers come with a readability program included in the software or you can purchase these software programs for $50-$75 extra. These work only on material already in the computer so anything you write yourself can be analyzed. The Fry Readability formula is accurate at lower reading levels. One can use the FRY formula on material not in the computer. The Word Perfect 6.0 package contains *Grammatik - Interactive Check.* For additional information on how to use the FRY formula, contact your local health educator or check with your local elementary school reading teacher.

This process can be simplified by using a computer scanner and a software package of readability formulas. This determination is important because it is preferable to communicate at the sixth to eight grade reading level.

It may not be enough to provide information and assume the learner will absorb it with a resultant change in behavior. Therefore, it is necessary to determine if the learner understands and assimilates the contents. Sample questions can be written for the patient to answer in order to determine his level of understanding. The addition of questions and the patient's response (verbal and written) can be included in the patient's record and serves as evidence of informed consent. Many current education materials include questions accompanying the resource. This may be adapted to audio and video as well. Interactive videos already employ this concept.

At larger sites, a data software program can be used for cataloging. Resources are then easily indexed and retrieved by key words. Catalog citations can be changed using the same program. Reproduction of citations can be generated on the computer for distribution to patients to select materials. A checkoff sheet indicating resources provided to a patient can be filled in the patient's chart. Filing actual materials in the library or filing cabinet should be set up for ease of retrieval. The catalog and collection should be frequently updated to stay current and weed out resources made obsolete by new medical advances.

Budget

Developing a specialized library can be cost effective. All of the team member tasks can be accomplished during ordinary working hours. Equipment cost can be minimized as most hospitals and clinics have access to a Xerox machine, computer and printer. One useful software program to consider purchasing includes a database and a scanner to decrease the time needed to determine the educational reading level. Usually a filing cabinet and folders can house the accumulated materials.

In summary, a patient library is feasible and beneficial to patients and health professionals alike. Setting goals, objectives, and determining the process at the beginning expedites development and leads to an appropriate and useful library collection.

ASSESSMENT OF PATIENT EDUCATION MATERIALS

I. Who are the professional clinicians and what is their interest and dedication to patient education?

II. Staff Profile:

Name Title/Training Special Area of Interest/or expertise

III. Patient Profile:

A. Number of patients
B. Age/sex distribution
C. Morbidity report (20 most common diagnoses)
D. Past years' history of services

l. Health maintenance visits (including OB-Gyn, Yearly PE)
2. Laboratory/procedures (EKG, Pulmonary function, blood sugar, Cholesterol.)
3. Facility health maintenance procedures (flex. sign. etc.)

IV. Community Resource Profile

A. Agencies or professionals to whom patients are referred
B. Community involvement by facility personnel for HPDP

V. Facility Resources
A. Personnel currently involved in various aspects of education: Responsibilities
B. Space in the office being used for patient education
C. Types of materials currently being used now, or would like to add for patient education
D. Primary sources of educational materials
E. Criteria used for selecting materials
F. Personnel responsible for selecting materials
G. Storage arrangement for materials
H. Audio-visual teaching aids available
I. Availability of computer, copier, word processor, document storage
J. Budget available for education
K. How to recover cost of education

VI. Setting practice goals

A. Assessment
B. Planning/development
C. Staff orientation
D. Evaluation

VII. Identify constraints

Financing Patient Education

Excerpts from:

Managing Hospital-Based Patient Education

Barbara E. Giloth

and

Financing Patient and Family Education at the Hospital Level

Sue Pritchett:

In the past, whatever health/patient education received ("whenever" and "if ever,") was received when we went to the doctor's office, a clinic, or a hospital. Now we are being encouraged to take the "whatever, whenever, and if ever" out of patient education and we are being encouraged to provide education that is "for sure," consistent, organized, and accountable.

Clinic Health Directors and Hospital Administrators are encouraged to look at what they are doing now and many are saying, "To do this right is going to cost money; who is going to pay for it?" The fact that patient education can also contribute to cost containment is of little help at first, because it usually does require money (in terms of more staff time, and in many instances -- more staff) to bring patient education to reality.

Current Status of Reimbursement for Patient Education Services

Although the financing of health care has changed substantially since the landmark document *Financing for Health Education in the United States* was written in 1980, there has basically been little change in the overall status of reimbursement for patient education. Patient education that is integral to care, part of the treatment plan, and delivered under the supervision of a physician has been and continues to be allowable as an administrative expense under nearly all third-party payer policies; yet it is still rare to find specific patient education programs, other than diabetes patient education, reimbursed as a separate service.

Although *Current Procedural Terminology* (CPT) codes currently exist for group counseling sessions, most public and private insurance plans do not provide separate coverage for these services. Codes only establish a mechanism for billing; they cannot guarantee third-party reimbursement.

Medicaid: Medicaid is the federal-state government program that finances health care for specified low-income individuals. By federal mandate, certain basic services must be offered by states to all categorically needy Medicaid enrollees.

Several key reimbursement problems are specific to Medicaid. First, many states have set reimbursements rates so low that hospitals and clinics lost money for every Medicaid patient they service. It is currently estimated that on the average Medicaid pays $.80 for every dollar of care provided. Second, the Medicaid programs currently cover a smaller and smaller percentage of those below the federal poverty level; in 1976 35 percent of such persons were not covered. By 1991, this figure had soared to 60 percent. Therefore, no matter what policies the actual state Medicaid programs chooses to implement, a growing percentage of the poverty population has no coverage for basic medical care, let alone patient education services.

Medicare: Medicare is the federal government program that provides health care to elderly and disabled individuals. Since its inception in 1965, Medicare reimbursements have been limited to care that is "reasonable and necessary for the treatment of an illness or injury." In general, Medicare does not cover primary preventive services for people who are well.

Although more than 450 Bills have been introduced since 1965 that have sought to add various preventive benefits under the Medicare program, the only Bills that have been enacted reflect a bias toward immunization and screening rather than education and counseling. Currently the only preventive services covered broadly include immunizations for beneficiaries at high risk of contracting hepatitis B, Pneumococcal pneumonia immunizations, pap smears, and mammograms.

Medicare will expand access to preventive services for eligible patients using Federally Qualified Health Centers receiving a grant under Sections 329, 330, and 340 of the Public Health Service Act. According to regulations published in the June 12, 1992 *Federal Register*, preventive primary services - including nutritional assessment, preventive health education, and immunizations - will be covered when provided in these settings. Specifically excluded are group or mass information programs, health education classes, or group education activities including media productions and publications.

The introduction in 1983 of the prospective pricing system and diagnosis-related groups (DRGs) essentially put an end to hopes that inpatient education might be reimbursable as a separate line item. Concern about patients being discharged "quicker and sicker," however, has resulted in more attention being paid to discharge preparation. Although never enacted, legislation introduced in 1992 - the Medicare Prevention Benefits Act - would provide reimbursement for risk assessment, preventive interventions, and counseling for persons first becoming eligible for Medicare.

As with Medicaid programs, hospitals and clinics can expect to lose a significant amount of money caring for Medicare patients. Newly released data suggests that hospitals and clinics can expect to pay out more than they receive for taking care of hospitalized Medicare patients.

Private Health Insurance Plans

Traditionally, private health insurance plans have covered patient education and related services in one of four ways. Most commonly, such services have been covered through incorporation into administrative costs. Less frequently, insurers have offered a benefit package that includes specified patient education benefits, for example, cardiac rehabilitation. They may also offer incentives to maintain healthy behavior or provide health education program.

In 1991, Blue Cross and Blue Shield Association issued guidelines designed to serve as the basis for a model preventive services benefit. Based on screening guidelines developed by the U.S. Public Health Service and the American College of Physicians, coverage includes well-baby care, childhood immunizations, and routine adult medical screening tests for cancer, heart disease, and other preventable illnesses.

Statements made by various health insurance groups all agree that patient education that is integral to the patient's treatment plan is a legitimate cost of patient care and should be reimbursed under existing reimbursement mechanisms. Many hospitals and clinics have interpreted this to mean that separate charges could be made for patient education and reimbursed by third-party payers. Some hospitals and clinics have hired "patient educators" to teach patients on a referral basis and established a charge of something like $10 per hour for this service. This method of improving patient education has disadvantages -- only one of which is that the charge is not usually reimbursable and the patient is then required to pay for it out of pocket.

If you talk to a major third-party payer and ask if they cover patient education, they will probably say, "Yes, we do. We consider patient education to be a basic part of patient care and we have always reimbursed for it through the basic rate. If we paid for it as a separate charge, we would be paying for it twice." They know that in reality education may or may not be provided but they shrug and state they are already paying for patient education.

Although there has been some disagreement about how this cost should be reimbursed, most insurance companies have agreed that any increased costs for patient education should be incorporated into the hospital or clinic's normal charge or rate. "If it costs more money - change the rate but not the rate structure. If it means increasing the education budget or the patient care budget, do it, and let it be subjected to the same scrutiny as all other elements of reimbursement."

Strategies to Increase Third-Party Reimbursement

Although the overall third-party reimbursement climate is not favorable for the separate reimbursement of patient education, there are some opportunities to increase payments for services that are largely education in nature. The following five steps offer suggestions on assessing opportunities for reimbursement.

1. *Assess extent of current patient education reimbursement.* This first step involves data collection to determine the current status of reimbursement for patient education services offered by the hospital or clinic. The following data should be gathered:

   • What charges are currently generated from patient education services?
   • Are any of the charges for patient education service submitted for third-party reimbursement?
   • Of the charges submitted for third-party reimbursement is any portion reimbursed?
   • Do any of the managed care contracts negotiated by the hospital include PFCE services? If so, was any consideration given to the amount of resources required to implement these services?
   • Does the Health Director/Administrator think it would be useful to pursue additional reimbursement for patient education services?

2. *Assess the overall payer environment.* This information is critical to identifying opportunities for potential expansion of reimbursement. Strategic planning may have identified data regarding local employers and their health care benefit plans. The Chamber of Commerce may be sources of local employer information. State, local and county health departments may provide data on the existence of state-mandated benefits. The following data should be gathered:

   • What is the clinic or hospital's payer mix? Are patients primarily covered by public programs, or is there substantial private coverage?
   • Who are the largest insurers for the clinic or hospital's major services? Be as specific as possible.
   • Do any employer groups comprise a significant component of the clinic or hospital's inpatient or Outpatient caseload?
   • To what extent is managed care plans a significant component of the clinic's market share?
   • How are EPSDT services provided in the community? EPSDT: Under the Early Periodic Screening, Diagnostic, and Treatment Program enacted by Congress in 1967, states are required to provide health assessments and examinations and immunizations to all Medicaid-eligible children under the age of 21. Many states have done a limited job of informing eligible parents of the availability of this program, and restrictions on access to services and provider qualifications have limited the number of children receiving services.
   • Are there state-mandated patient education prevention service benefits?
   • To what extent are the major employers, including the hospital, self-insured?
   • To what extent do the physicians on the staff offer patient education services, and to what extent are they reimbursed for them?

3. *Assess payer interest.* Although the third-party payer policies represent overall directions for reimbursement, individual commercial insurers and individual insurance companies set local priorities. State Medicaid plans differ, and the fiscal intermediaries for Medicare often interpret regulations different. Any initial strategy in reaching theses payers is to meet with the appropriate staff members to gather the following information:

   • How does each payer view the scope and importance of patient education?
   • Does the payer reimburse for an education service, such as a smoking cessation program, if it is a part of cardiac rehabilitation?
   • Would the payer consider reimbursing for a patient education service in the future?
   • Would the payer consider a pilot project to look at such reimbursements?
   • Do local payers offer patient education or health promotion services directly to subscribers? If so, is there an opportunity to contract with hospital or clinic staff as providers?

   • Are local payers willing to support hospital or clinic-sponsored patient education or community health education programs through financial or in-kind contributions?

4. *Focus on patient education services with a high likelihood for reimbursement.* Reimbursement is most likely for outpatient chronic disease services that seek to ensure that the patient and family have the skills they need to manage the condition in question.

5. *Integrate patient education into outpatient care*. A large percentage of outpatient education services are activities that should be integrated into the routine delivery of outpatient care, especially primary care. Quality patient education requires assessment, problem solving, and reinforcement over time at every visit. The clinic or hospital staff should examine their current services to ensure that these services are integrated efficiently and consistently. No third-party payer will seriously consider any present or future reimbursement unless it can be demonstrated that patient education occurs on a planned, consistent basis.

Strategies to Increase Resources

1. Clarify the hospital or clinic's financial goals
2. Specify needed resources
3. Increase administrative support for patient education.
4. Identify other management opportunities to influence the budget
5. Increase efficiency
6. Collaborate internally and externally
7. Diversify by tapping into other funding sources
8. Train volunteers

When we talk about improving patient and family education, we are not referring only to special disease categories such as diabetes. Patient education means clear and complete information exchanged between all patients and all staff members during the routine course of treatment -- when a new procedure is about to be performed, when the patient is being screened, or when a patient asks a question. It means making sure that the patient knows about home care, and it means documenting this on the chart in a meaningful way.

Improved patient education is achieved in a number of ways:

(1) by helping staff stay up-to-date in the various diseases and conditions of the patients they treat so that they are comfortable with the content of what patients need to know;
(2) by helping staff become more sensitive to patient education and information needs and better able to communicate with patients;
(3) by organized responsibility with multidisciplinary involvement -- to insure that all patients receive the education they need with no contradictions and no gaps;
(4) by hospital or clinic administrative commitments.

One additional consideration needs scrutiny and this concerns the employment of a full-time “Patient Educator” versus patient education being provided by all the staff.

Sometimes a facility hires a full-time “Patient Educator,” usually a nurse or health educator, with the responsibility of patient teaching. Some see patients on a referral basis and make a separate charge. In most instances, this has been found to be very limited because they can only see a few patients a day and it sometimes actually deprives many patients of instruction they would have received prior to the employment of a full-time Patient Educator. The result is that staff who would routinely have provided this service (when they had time) discontinued any attempt to teach the patients because it was now somebody else’s job. Hospitals and clinics that employ such a position are in the process of changing to a true collaboration role where the educator works primarily with staff in organizing and supporting education efforts and in identifying education needs at the hospital or clinic-wide level so that activities/efforts can be directed toward meeting the most critical areas of need.

The same general rules for outpatient services apply with third-party coverage. If the charge for education is built into the basic service or visit charge, it should be eligible for reimbursement as any other basic service charge and should be considered on the same basis as an inpatient charge. Medicare has indicated that they expect to pay for education on an outpatient basis or even home visits just as they would for inpatients if the education is integral to the treatment plan.

Part of our problem is that we do not figure in the educational or communication time involved in treatments and procedures when we establish fees for outpatient services. Further, most Administrators do not set aside any funds for patient education even though they assume that the clients using their facilities are receiving patient education.

Hospital and Clinic Administrators need to consider taking a certain percentage right off the top of the budget that could be allocated to patient education services. Hospital and Clinic Administrators also need to consider billing for other services, such as nutrition counseling -- especially if the nutritionist is a licensed or Registered Dietitian. There are some private insurance companies that will reimburse for certain types of patient education/counseling **IF** the provider is licensed or registered in their profession.

Finally, Institutions need to eliminate the use of the phrase; "I don't have time to teach because I'm busy treating other patients." Education is treatment. If a person is sick with an infection, the treatment is antibiotics; if the person is sick because of ignorance, the treatment is education.

Diabetes Reimbursement

Coverage of Diabetes Outpatient Self-Management Training Services: Effective July 1, 1998
The Balance Budget Act of 1997

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of diabetes outpatient self-management training services when these services are furnished by a certified provider who meets certain quality standards.

A diabetes outpatient self-management and training service is a program which education beneficiaries in the successful self-management of diabetes. An outpatient diabetes self-management and training program includes education about self-monitoring of blood glucose, diet, and exercise, an insulin treatment plan developed specifically for the patient who is insulin-dependent, and motivates patients to use the skills for self-management.

Outpatient self-management training services may be covered under Medicare only if the physician who is managing the beneficiary's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the beneficiary's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) in the management of the beneficiary's condition.

Certified Providers: The statute states that a "certified" provider is a physician or other individual or entity designated by the Secretary that, in addition to providing outpatient self-management training services, provides other items and services for which payment may be made under Title XVIII, and meets certain quality standards. For initial implementation of this benefit we are designating as a certified provider those physicians, individuals or entities that are paid under the physician-fee schedule. These certified providers must meet the National Diabetes Advisory Board Standards (NDAB) as subsequently revised.

Along with physicians we will designate as certified providers other nonphysician practitioners who meet NDAB standards and whose services are paid for under the physician's fee schedule. These services may be provided in two ways:

1) First, the services performed by non-physician practitioners may be incident-to a physician's professional services, must be an integral, although incidental part of the physician's personal professional services, and must be performed under the physician's direct personal supervision.
2) Second, a non-physician practitioner such a Physician Assistant or Nurse Practitioner may be licensed under State law to perform a specific medical procedure and may be able to perform the procedure without a physician's supervision and have the services separately covered and paid for directly by Medicare as a Physician's Assistant or Nurse Practitioner service. Medicare only covers procedures and services that are performed in accordance with State license.

In keeping with the requirements of the legislation, services provided by individuals other physicians will be covered when they are provided within the current coverage requirements. These include: Physician Assistants (PAs), Nurse Practitioners (NPs), Nurse Midwives (NMs), Clinical Psychologists (CPs), and Clinical Social Workers (CSWs).

HCFA-Pub. 60-AB
The rules for Billing and payment to Non-Physician Practitioners Providing Diabetes Outpatient Self-Management and Training.

Employers of PAs must bill Part B of the Medicare program for professional services furnished by the PA, as well as services furnished as an incident-to the professional services of a PA. The PA's physician supervision (or a physician designated by the supervising physician or employer as provided under State law or regulation) is primarily responsible for the overall direction and management of the PA's professional activities and for assuring that the services provided are medically appropriate for the patient. Pursuant to section 4512 (c) of the Balanced Budget Act Medicare payment for PA services is made only to the PA's employer regardless of whether the PA is employed as a W-2 employee or whether the PA is acting as an independent contractor. Also, while a PA has an

option in terms of selecting employment arrangements, only the employer can bill a carrier or intermediary for the PA's services.

Any service furnished by a PA must be furnished under the general supervision of a physician. General supervision does not require the physician to be present on the premises and immediately available while all services are being furnished. Rather, the physician may be reached by telephone in care of an emergency. However, any services furnished incident-to the professional services of the PA must be furnished while the PA is present on the premises and immediately available in case of an emergency while these ancillary services are being furnished. Accordingly, any service furnished incident to the professional services of a PA must comply with all of the "incident-to" requirements mentioned above.

Clinical Nurse Specialist's and NPs may bill the Medicare Part B program directly for services that are performed in collaboration with a physician. They may also bill the program directly for services furnished as an incident to their professional services in which case the direct supervision requirement in particular and all the incident-to requirements apply.

We are requiring that CNs, NPs, and the employers of PAs must submit claims to the Part B carrier under their own respective billing numbers for their professional services furnished in facilities or toerh provider settings except in the case where the services of these nonphysician practitioners are furnised to patients in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). Payment for these services of these nonphysician practitioners in the RHC/FQHC setting is bundled under the facility cost payment that is made by the intermediary under the all inclusive rate.

Coding and Payment: When a provider bills for diabetes self-management training services they should use the following CPT codes:

G0108 – Diabetes outpatient self-management training services, individual session, per 60 minutes of training.

G0109 - Diabetes outpatient self-management training services, group session, per 60 minutes of training.

We will allow $55.41 (practice expense relative value unit (RVU) of 1.51) per hour for an individual session and $32.62 (RVU of .89) per beneficiary per hour in a group session. Like other services paid under the physician fee schedule, the actual payment amounts will vary among geographic areas to reflect differences in costs of practice as measured by the Geographic Practice Cost Indexes.

Standards that certified providers must meet: (Currently under revision)

1. Structural Standards

   A. Organizational Support by Sponsoring Organizations
      - Standard 1: Maintain written policy affirming education as an integral component of diabetes care.
      - Standard 2: Provide education resources needed to achieve objectives for target population, including adequate space, personnel, budget and instructional materials.
      - Standard 3: Clearly define and document organizational relationships, lines of authority, Job descriptions, staffing, and operational policies.

   B. Community Needs Assessment
      - Standard 4: Assess service area to define target population and determine appropriate Allocation of personnel and resources

   C. Program Management
      - Standard 5: Establish standing advisory committee including at least a physician, nurse Educator, dietitian, behavioral science expert, consumer, and community Representative to oversee the program.
      - Standard 6: The Advisory committee should participate in annual planning to determine Target population, program objectives, participant access, and follow-up Mechanisms, instructional methods, resource requirements and program

Evaluation.

- Standard 7: Professional program staff should have sufficient time and resources for Lesson planning, instruction, documentation, evaluation and follow-up.
- Standard 8: Assess community resources periodically.

D. Program Staff

- Standard 9: Designate a coordinator responsible for program planning, implementation, and Evaluation.
- Standard 10: Program instructors should include at least a nurse educator and dietitian with Recent didactic and experiential training in diabetes clinical and educational Issues. Certification as a Diabetes Educator by the National Certification Board of Diabetes Educators is recommended.
- Standard 11: Professional program staff should obtain continuing education about diabetes, Educational principles, and behavioral change strategies.

E. Curriculum

- Standard 12: The program must be capable of offering, based on target population needs, Instruction in the following 15 Content Areas:
  1. diabetes overview
  2. stress and psychosocial adjustment
  3. family involvement and social support
  4. nutrition
  5. exercise and activity
  6. medications
  7. monitoring and use of results
  8. relationships among nutrition, exercise, medication, and glucose levels
  9. prevention, detection and treatment of acute complications
  10. prevention, detection and treatment of chronic complications
  11. foot, skin, and dental care
  12. behavior change strategies, goal setting, risk factor reduction, and problem-solving
  13. benefits, risks and management options for improving glucose control
  14. preconception care, pregnancy, and gestational diabetes
  15. use of health care systems and community resources
- Standard 13: Use instructional methods and materials appropriate for the target population.

F. Participant Access

- Standard 14: Establish a system to inform the target population and potential referral sources of availability and benefits of the program.
- Standard 15: The program must be conveniently and regularly available.
- Standard 16: The program must be responsive to requests for information and referral sources Of availability and benefits of the program.

II. Process Standards

A. Assessment

- Standard 17: Develop and update an individualized assessment for each participant, including Medical history and health status; health services utilization, risk factors; diabetes Knowledge and skills; cultural influences; health beliefs; attitudes; behavior and Goals, support systems; barriers to learning; and socioeconomic factors.

B. Plan and Implementation

- Standard 18: Develop an individualized education plan, based on the individualized assessment, In collaboration with each participant.
- Standard 19: Document the assessment, intervention, evaluation, and follow-up for each Participant, and collaboration and coordination among program staff and other Providers, in a permanent record.

B. Follow-Up

- Standard 20: Offer appropriate and timely educational interventions based on periodic

Reassessments of health status, knowledge, skills, goals, and self-care behaviors.

III. Outcome Standards
   A. Program
      - Standard 21 The advisory committee should review program performance annually, and use The results in subsequent planning and program modification.
   B. Participant
      - Standard 22: The advisory committee should annually review and evaluate predetermined Outcomes for program participants.

Carrier Billing Requirements
Providers should bill for their professional services using CPT code G0108 and G0109 on the form HCFA-1500. When billing for these codes the certified provider must on the first claim, provide you with a copy of its "Certificate of Recognition" from the American Diabetes Association that affirms they are a recognized provider. For the initial office visit the provider should bill an evaluation and management code. Thereafter, one of the new diabetes self-management education codes should be used. The statute requires that physicians and other individuals must provide other items and services for which payment may be made under title XVIII. However, this does not prevent new physicians or entities who did not previously possess a billing number from simultaneously obtaining a billing number and becoming a certified provider.

Apply the deductible and coinsurance.

Billing Requirements for Intermediaries
The provider bills for diabetes self-management training services on the HCFA-1450 or its electronic equivalent. The cost of the service is billed under revenue code 51X in FL 42 "Revenue Code." The provider will report CPT codes G0108 or G0109 in FL 44 "HCPCS/Rates." The definition of the CPT codes used should be entered in FL 43 "Description." As mentioned above, when a provider bills for these codes, they must on the first claim, provide you with a copy of its "Certificate of Recognition" from the American Diabetes Association that affirms they are a recognized carrier.

Apply the deductible and coinsurance.

Applicable Bill Types

The appropriate bill types are 11X, 12X, 13X, 71X, (Provider-based and independent), 72X, 73X, (Provider-based and freestanding), 83X and 85X.

Medicare Summary Notice (MSN) and Explanation of your Medicare Benefits (EOMB) Messages
Intermediaries and carriers that have not yet converted to MSN should utilize the following EOMB messages.

Intermediaries who have converted to MSN should utilize the following EOMB messages.

If the claim is denied because the procedure code or revenue is invalid, use the following message:

"The item or service was denied because the information required to make payment was incorrect." (MSN message 9.4) or "Medicare cannot pay for this because your provider used an invalid or incorrect procedure code and/or modifier for the service you received. (EOMB message 9.21)

SOAP PROGRESS NOTES

SOAP NOTES

A. Definition of SOAP

S - SUBJECTIVE DATA

Includes information from the client, such as the client's description of pain or the acknowledgment of fear. Including subjective input from the client aids in his participation in the plan of care.

O - OBJECTIVE DATA

Objective data is data that can be measured. Physical examinations, laboratory data, observations, and results of x-ray examinations are sources of objective information.

A - ASSESSMENT

The assessment is an interpretation of the client's condition or level of progress. The conclusions made in the assessment are more than a restatement of the original problem. The assessment determines whether the problem has been resolved or if further care is required.

P - PLAN

Plans may include specific orders designed to manage the client's problem, collection of additional data about the problem, individual or family education, and goals of care. The plan in each SOAP note is compared with the plan in previous notes. A decision is made to revise, modify, or continue previously proposed interventions.

_____

I - INTERVENTION

This section of the SOAP note is optional and can be used as a continuation of the original SOAP note. It may include the client's response to the intervention.

E - EVALUATION

This section is commonly used to conclude the SOAP note. It includes a brief summary of the plan. Evaluates if the plan was effective or needs revision. If the plan needs to be revised, it will be stated in the evaluation section and a new SOAP note will then be written.

Sample SOAP Note:

Isolation - lives alone.

S - "I just don't have any friends or family close by to help take care of me. I'm afraid I may make a mistake when I give myself a shot."

O - Client is learning to self administer insulin injections. Has no resources at home to supervise injections. Client has the psychomotor skills needed to perform injections correctly. Has been able to correctly administer injection for the last 2 days.

A - Client fearful of returning home without available resources to supervise injections.

P - A plan of action to call Home Health to refer client. Continue practice sessions with injections and offer encouragement appropriately. Assist client in planning for acquisition of necessary syringes and supplies.

APC Reports from PCC Files

This set of reports examines PCC files and counts all APC visits in a given time frame for the facility that you select. The following reports are available:

APC Reports	
1A	PCC-Ambulatory Patient Care Report 1A
DATE	APC Visit Counts by Date of Visit
CLN	APC Visit Counts by Clinic
DISC	APC Visit Counts by Provider Discipline
PROV	APC Visit Counts by Individual Provider
DX	APC Visit Counts by Primary Diagnosis (APC Code)
LOC	APC Visit Counts by Location of Service

Entry of all date into the PCC includes a designation of Location of Visit, Type of visit, and Service Category. Location of Visit consists of the facility name where the visit occurred (e.g. Crownpoint Hospital, Yakama Clinic, etc.) Types of Visit include the following:

IHS	Other
Contract	638 Program
Tribal	VA

and the Service Categories are:

Ambulatory	Not Found
Hospitalization	Day Surgery
In-Hospital Care	Observation
Chart Review	Event (Historical)
Telecommunications	Nursing Home Care

These three visit attributes, plus the Clinic Type designation for outpatient clinic visits, are used together to determine whether or not a visit is an "official APC visit" for inclusion in the IHS data system. The criteria for inclusion are listed below. Data displayed on this set of "APC Reports from PCC files" should correspond very closely to the reports received from the IHS Data Center. However, please be aware that for Service Unit management purposes, a similar set of reports containing more complete data, such as Not Found Visits, CHN Home Visits, and Telephone Calls may be found in the set of reports entitled "PCC Ambulatory Visit Counts," which are described in the next section of this manual.

In order to be considered an APC Visit, the Visit must meet the following criteria:

1. The visit must fall within the date range specified by the user.
2. The visit must have other medical data linked to the visit record.
3. The visit must be for one of the following service categories:
   Ambulatory
   IHS
   638 Program
   Day Surgery
   Observation
   Nursing Home
4. The visit must be one of the following Visit Types:
   IHS
   638 Program
   Tribal

Other

5. The visit must have a primary Purpose of Visit entered. (POV cannot be uncoded DX - .9999.
6. The visit must have a valid location pointer.
7. The visit cannot be to one of the following clinics:
   Mail
   Telephone Call
   Chart Review
   Follow-up Letter
   Radio Call
   Dental
   Education Class
   Employee Health
8. The visit must have a valid primary provider entered.
8. If the primary provider discipline is 13 (CHN) or 32 (CHR) and the location of the visit is other than an IHS facility (code >49), the visit is excluded.

The user is prompted to enter the visit date range to be used in calculating the number of visits and also will be asked whether visits for ALL locations should be included or whether visits for one particular location should be included.

PCC
AMBULATORY PATIENT CARE
REPORT 1A [A]

This report is generated from PCC files and is very similar to the 1A report generated by the APC System at the Data Center in Albuquerque. The report will display Fiscal Year-to-date APC Visit counts by Month of Service. Totals will be generated for each month as well as for each provider discipline. Percent totals are displayed for each discipline. total Primary Care Provider visits are subtotaled.

Primary Care Providers are defined as a primary provider with one of the following discipline codes:

00 -	Physician	44	-	Physician (Tribal)
11 -	Physician Assistant	70-90	-	Physician Specialist
16 -	Pediatric Nurse Practitioner	18	-	Contract Physician
17 -	Nurse Midwife	25	-	Contract Podiatrist
21 -	Nurse Practitioner	41	-	Contract OB/GYN
33 -	Podiatrist			

The user is prompted for the FY for which to run the report and for the facility for which the report should be run.

A sample Report 1A is displayed on the next page.

Estimated Run Time:

On a Class "A" Altos computer, running without competition from other users (i.e., after hours), this job takes approximately 1.3 minutes per 1,000 visits being processed.

DEFINITION OF AN AMBULATORY CARE VISIT

Definition: An encounter between a patient and health care provider in an organized clinic within an IHS (638 included) facility where service resulting from the encounter is not part of an inpatient stay.

Requirement: Patient or his/her representative must be physically present at the time of service.

* Representative only to pick-up prescriptions.

Note written in the medical record by a licensed or credentialed provider found to be qualified and approved for privileges by the medical staff and facility administrator.

The date of the visit is the date the visit was initiated. e.g., Patient enters ER at 2330 and departs at 0100.

The following service is considered an Ambulatory Care Visit:

Patient served by physical or other provider within an IHS (or 638) facility where such service is documented and authenticated within the medical record.

NOTES: The category or provider must be listed within the IHS Standard Code Book.

A visit to two ORGANIZED APPROVED IHS (638) clinics on the same day counts as two Ambulatory Care Visits.

A visit to two physicians within the same IHS (638) clinic counts as one Ambulatory Care Visit.

Renal dialysis provided by contract provider in an IHS (638) facility will be counted as a physician provided Ambulatory Care Visit.

A dental prescription filled in the pharmacy is a pharmacy visit.

The following services <u>are not</u> an Ambulatory Care Visit:

- A prescription change based upon telephone conversation between provider and patient is not an Ambulatory Care Visit.
- Follow-up communication by telephone or letter is not an Ambulatory Care Visit.
- A letter written by a physician or other provider on behalf of a patient.
- A visit to provide patient care within a nursing home.
- Patient Care provided to patients in any non-IHS (638) facility.
- Patient care that is not documented and authenticated in the medical records.
- Patient care provided by Community Health Representatives. (CHR's)

CONTRACT HEALTH REPORTING
Similar encounters in the private sector that are purchased by the IHS will be counted as CHS visits.

DENTAL VISITS
Dental visits are not defined as Ambulatory Care Visits for purposes of the IHS statistical reporting.

Dental visits that are purchased by the IHS will be counted as CHS Dental visits.

This form is used to record services provided in group settings for entry into the PCC. Examples include blood pressure and hearing screenings; selected lab test results; PPD readings; and group education sessions where assessment of individual patient understanding is determined. Patients should be individually identified in the columns above and the individual services provided indicated for each patient. Different types of service can be recorded on a single form and multiple services may be recorded for individual patients.

PROVIDER (SERVICES RENDERED BY) CODES

1. Services Rendered by:
   - A Two Digits
   - B Designates who renders service.
   - C The Provider Codes and Definition are as follows:

00 - MD A doctor of medicine or doctor of osteopathy who, by virtue of education, training, and demonstrated competence, is granted clinical privileges by the organization to perform specific diagnostic or therapeutic procedure(s) and who is fully licensed to practice medicine.

01 - CLINIC RN - An individual who is qualified by an approved postsecondary program or Baccalaureate or higher degree in nursing and licensed by the state, commonwealth, or territory to practice professional nursing.

02 - ENVIRONMENTAL HEALTH

03 - HEALTH AIDE

04 - HEALTH EDUCATOR

05 - LICENSED PRACTICAL NURSE (LPN) - A nurse who has completed a practical nursing program and is licensed by a state to provide routine patient care under the direction of a registered nurse or a physician.

06 - MEDICAL SOCIAL WORKER

07 - NUTRITIONIST - An individual who is a specialist in nutrition.

8 - OPTOMETRIST - An individual who is a specialist in optometry. The profession of examining the eyes and measuring errors in refraction and of prescribing glasses to correct the defects.

09 - PHARMACIST - who has a degree in pharmacy and is licensed and registered An individual to prepare, preserve, compound, and dispense drugs and chemicals.

10 - PHYSICAL THERAPIST - An individual who is a graduate of a physical therapist education program accredited by a nationally recognized accrediting body; who meets any current legal requirements of licensure or registration or who has the documented equivalence in training, education, and experience; and is currently competent in the field. Physical therapists assess, evaluate, and treat movement dysfunction and pain resulting from injury, disease, disability, or other health-related conditions.

11 - PHYSICIAN ASSISTANT

12 -- PSYCHOLOGIST - An individual who specialized in psychological research, testing, or therapy; deals with the emotional and mental processes, consciousness, sensation, ideation, and memory.

13 - PUBLIC HEALTH NURSE

14 - SCHOOL NURSE - An individual who is either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) who is identified as a school nurse.

15 - OTHER

16 -- PEDIATRIC NURSE PRACTITIONER

17 -- NURSE MIDWIFE

18 - CONTRACT PHYSICIAN

19 - MENTAL HEALTH

20 - MEDICAL STUDENT

21 - NURSE PRACTITIONER

22 - NURSE ASSISTANT

23 - LABORATORY TECHNICIAN

24 - CONTRACT OPTOMETRIST

25 - CONTRACT PODIATRIST

26 - INHALATION THERAPIST

27 - STUDENT NURSES

28 -AUDIOLOGIST - A specialist in evaluation, habitation, and rehabilitation of those whose communication disorders center in whole or in part in the hearing function. An individual who has a master's degree from an audiology program approved by a nationally recognized professional accrediting body; who has completed a supervised clinical fellowship year and passed a national examination in audiology or has the documented equivalent in education, training, or experience; and who meets any current legal requirements for licensure.

29 - DIETITIAN - An individual who is an expert in dietetics; one versed in the practical application of diet in the prophylaxis and treatment of disease. An individual who completed the minimum of a Baccalaureate degree granted by a U.S. regionally accredited college or university; meets current academic requirements (Didactic Program in Dietetics) as approved by the American Dietetic Association; successfully completed the Registration Examination for Dietitians; and accrues 78 hours of approved continuing education every five years.

30 - PHARMACY PRACTITIONERS

31 - OPTOMETRIC ASSISTANT

32 - CONTRACT PUBLIC HEALTH NURSE

33 - PODIATRIST - An individual who has received the degree of doctor of podiatry medicine and who is licensed to practice podiatry.

34 - TRIBAL/CONTRACT NUTRITIONIST

35 - OUTREACH WORKER

36 - EYE CARE SPECIALIST

37 - FAMILY PLANNING COUNSELOR

38 - EMT/PARAMEDIC

39 -- SPEECH THERAPIST

40 -- AMBULANCE DRIVER - An individual who performs the duty as an ambulance driver.

41 - CONTRACT OB/GYN

42 - SPEECH/LANGUAGE PATHOLOGIST - An individual who holds either a master's or degree; the Certificate of Clinical Competence (CCC) of the American Speech-Language Association (ASHA); or has the documented equivalent education, training, or experience, and, where applicable, state licensure.

43 - AUDIOMETRIC TECHNICIAN

44 - TRIBAL PHYSICIAN

45 - OSTEOPATHIC MEDICINE

46 - DENTAL HYGIENIST - An individual who is skilled in the science of dental health. A dental health educator permitted by law to give dental prophylaxis and other preventive treatment. Professional education, 2 years for certificate, and 4 years for BS degree.

47 - CRNA

48 - ALCOHOLISM/SUB ABUSE COUNSELOR

49 - CONTRACT PSYCHIATRIST

50 - CONTRACT PSYCHOLOGIST

51 - PAPAGO NUTRITION PROGRAM

52 - DENTIST - An individual qualified by law to practice dentistry. The healing science and art concerned with the care and health of all the tissues comprising the mouth. Emphasis is placed on (1) the prevention, diagnosis and treatment of diseases of the teeth and gingivae; (2) the replacement of missing teeth; (3) the correction of irregularities in the structure of the teeth and jaws; and (4) the study and care of non-dental disease affecting the superficial and deep structures of the oral cavity.

53 - COMMUNITY HEALTH REPRESENTATIVE

54 - DENTAL ASSISTANT (PRENATAL)

55 - DISEASE CONTROL PROGRAM

56- HEALTH RECORDS - Individuals who are employees of the Medical Records/Health Records or Health Information Department.

57 --ADMINISTRATIVE- Individuals who are employees of the Administrative department.

58 - SPEECH THERAPY-DISCONTINUED

59 - XRAY TECHNICIAN

60 - DENTAL ASSISTANT

61 - DENTAL LAB

62 - LICENSED MEDICAL SOCIAL WORKER - An individual who either has met the requirements of a graduate curriculum (leading to a master's degree) in a school of social work that is accredited by the Council on Social Work Education or has the documented equivalent in education, training, or experience.

63 -- CONTRACT SOCIAL WORKER

64 - NEPHROLOGIST - An individual who specialize with the branch of medicine dealing with the kidney.

65 - OPTOMETRY STUDENT - An individual who is a student within the optometry program.

66 - CASE MANAGERS

67 - CLINICAL PHARMACY SPECIALIST - Pharmacists designated as CPS has medication prescribing authority and deliver primary care. Pharmacists designated as CPS are those pharmacists with a Doctor of Pharmacy degree (Pharm. D), pharmacists who have completed a pharmacy residency program, specialty board certified pharmacists with at least two years of equivalent.

68 - EMERGENCY ROOM PHYSICIAN

69 - CHIROPRACTOR - An individual who employs the doctrine and dogma of chiropractic. The science and art of restoring or maintaining health, based on the theory that disease is caused by interference with nerve function, and employing manipulation of the body joints, especially of the spine, in seeking to restore normal nerve function.

70 - CARDIOLOGIST - An individual having special knowledge and experience in the branch of medicine dealing with the heart, its functions, and its diseases.

71 - INTERNAL MEDICINE

72 - OB/GYN

73 - ORTHOPEDIST

74 - OTOLARYNGOL

75 - PEDIATRICIAN

76 - RADIOLOGIST - an individual who is a graduate of a radiological technology program accredited by an accreditation body recognized by the U.S. Department of Education; is currently certified as a radiologists; meets any current legal requirements of licensure or registration or has the documented equivalent in education, training, and experience; and is currently competent in the field.

77 - SURGEON

78 - UROLOGIST

79 - OPHTHALMOLOGIST

80 - FAMILY PRACTICE

81 - PSYCHIATRIST - A physician who specializes in assessing and treating persons having psychiatric disorders; is certified by the American Board of Psychiatry and Neurology or has the documented equivalent in education, training, or experience; and is fully licensed to

practice medicine in the state in which he or she practices.

82 - ANESTHESIOLOGIST

83 - PATHOLOGIST

84 -- PEDORTHIST - A person skilled in pedorthics and practicing its application in individual cases.

85 -- NEUROLOGIST

86 -- DERMATOLOGIST

87 -ULTRASOUND TECHNICIAN - A person trained in and expert in the performance of ultrasound technical procedures.

88 - CODING/DATA ENTRY

89 -- AUDIOLOGY HEALTH TECHNICIAN - A person trained in and expert in the performance of audiology technical procedures who assists the ENT practitioner.

90 -- OCCUPATIONAL THERAPIST - A person skill in the therapeutic use of self-care, work and play development, and the environment to enable the patient to achieve maximum independence and to enhance the quality of the patient's life.

91 -- PHN DRIVER/INTERPRETER - A person who provides assistance to the PHN.

92 -- PSYCHOLOGIST - A person who provides treatment of mental disorders and behavioral disturbances using such psychological techniques as support, suggestion, persuasion, re-education, reassurance, and insight in order to alter maladaptive patterns or coping and to encourage personality growth.

93-- TRADITIONAL MEDICINE PRACTITIONER - A person who is trained in a Native American community, applies culturally specific knowledge and skills in the diagnosis, treatment, or referral of patients to promote their well-being physically, mentally, socially, and spiritually.

94 -- MENTAL HEALTH SPECIALIST (BS/BA Only) - An individual who has a Bachelor of Art (BA) or Bachelor of Science (BS) Degree in Mental Health.

95 -- MENTAL HEALTH SPECIALIST (MASTERS DEGREE ONLY) - An individual who has a Masters Degree in Mental Health.

96 -- FAMILY THERAPIST - An individual who has a degree or is skilled in the treatment of group therapy of members of a family, with exploration of family relationships and processes as potential causes of mental disorder in one or more members of the family.

97 - NUTRITION TECHNICIAN

98 - FOOD SERVICE SUPERVISOR

99 - DIETETIC TECHNICIAN

A1 -- SPORTS MEDICINE - The role of a sports medicine physician addressed the physical, emotional and spiritual needs of the athlete in the context of sport and the needs of the team. This individual should be a primary care physician with additional training and experience in sports medicine.

CLINIC CODE DEFINITION

1. Type of Clinic Codes

A. Two Digit Codes
B. Type of Clinic Codes
C. The Codes and Definition are as follows:

01 CARDIAC - A prescheduled organized clinic that provides major diagnostic, medical treatment pertaining to the heart.
03 CHEST AND TB - A prescheduled organized clinic that provides major diagnostic, medical treatment pertaining to the chest and tuberculosis.
04 CRIPPLED CHILDREN -
05 DERMATOLOGY - A prescheduled organized clinic that deals with the branch of medicine that has to do especially with the study of the skin, its chemistry, physiology, histopathology, cutaneous lesions, and the relationship of cutaneous lesions to systemic disease.
06 DIABETIC
07 ENT (Ears, Nose and Throat) -
08 FAMILY PLANNING
09 GROUPED SERVICES - Use this code number when an "Ambulatory Patient Care Report Form" is prepared for an Indian or Alaska Native patient found with abnormal findings in a "Group Services" Clinic. See Indian Health Manual 4-3-1; Appendix 1, Section III for definition.
10 GYNECOLOGY (GYN) - A prescheduled organized clinic that deals with the branch of medicine which has to do with the diseases peculiar to woman, primarily those of the genital tracts, as well as female endocrinology and reproductive physiology.
11 HOME CARE
12 IMMUNIZATION
13 INTERNAL MEDICINE
14 MENTAL HEALTH (PSYCHIATRY)
15 OBESITY -
16 OBSTETRICS (OB) - A prescheduled organized clinic that deals with the branch of medicine that has to do with the care of the pregnant woman during pregnancy, parturition, and the puerperium.
17 OPHTHALMOLOGY - A prescheduled organized clinic that deals with the branch of medical science that has to do with the eye, its diseases of refractive errors.
18 OPTOMETRY - A prescheduled organized clinic that provides for refractive errors.
19 ORTHOPEDIC - A prescheduled organized clinic that deals with the medical specialty concerned with the preservation, restoration, and development of form and function of the extremities, spine, and associated structures by medical, surgical, and physical methods.
20 PEDIATRIC - A prescheduled organized clinic that deals with the branch of medical science that treats of children in their hygienic, physiologic, and pathologic relations; the specialty of the diseases of children.
21 REHABILITATION - A prescheduled organized clinic that deals with the restoration, following disease, illness, or injury, of ability to function in a normal or near normal manner.
22 SCHOOL - A prescheduled organized clinic that provides services to school age children.
23 SURGICAL - A prescheduled organized clinic that deals with the branch of medicine that has to do with external diseased and all other diseases and accidents amenable to operative or manual treatment.
24 WELL CHILD - A prescheduled organized clinic that provides services to well children.
25 OTHER - Include any "Organized Specialty" Clinic not identified above in addition to all patients whoa re seen outside of regularly scheduled clinic hours, and special situations defined in the Indian Health Manual 4-3.1A.2C.
26 HIGH RISK
27 GENERAL PREVENTIVE
28 FAMILY PRACTICE
29 in life or prevent critical consequences and that should be performed immediately.

31 HYPERTENSIVE
32 POSTPARTUM
33 INHALATION THERAPY
34 PHYSICAL THERAPY
35 AUDIOLOGY
36 W. I. C.
37 NEUROLOGY
38 RHEUMATOLOGY
39 PHARMACY
40 INFANT STIMULATION
41 INDIRECT
42 MAIL
43 ALCOHOL AND SUBSTANCE
44 DAY SURGERY - Also know as Ambulatory Surgery, Short-Stay Surgery, One-Day Surgery. A day surgery clinic for the performance of elective surgical procedures on patients who are classified as outpatients and typically are released from the surgery unit on the day of surgery.
45 PHN CLINIC VISIT - A patient encounter with the Public Health Nurse (PHN) only.
46 NIH CLINIC - For use only by Phoenix Indian Medical Center.
47 FETAL ALCOHOL SYNDROME (FAS) -
48 MEDICAL SOCIAL SERVICES
49 NEPHROLOGY - A prescheduled organized clinic that deals with the branch of medical science that deals especially with the kidneys.
50 CHRONIC DISEASE - A prescheduled organized clinic that deals with the branch of medical science that deals especially with chronic diseases.
51 TELEPHONE CALL - Contacts with individuals over the telephone.
52 CHART REV/REC MOD - Chart review(s) or a patient record modification is conducted.
53 FOLLOW-UP LETTER - A patient is sent a follow-up letter.
54 RADIO CALL - Contacts with individuals over a radio call.
56 DENTAL
57 EPSDT
58 CANCER SCREENING
59 VENEREAL DISEASE
60 EDUCATION CLASSES
61 DEVELOPMENTAL ASSESSMENT
62 CANCER
63 CAST ROOM - An area or location where a patient is provided follow-up care.
64. CHEMOTHERAPY
63 RADIOLOGY - The science that treats of radiant energy; of the chemical and other actions of rays proceeding from luminous bodies, from radium and other radioactive substances, and from x-rays; and of the sources of these rays.
64 RETINOPATHY - A prescheduled organized clinic that provides services for non-flammatory degenerative disease of the retina.
65 PODIATRY - A prescheduled organized clinic that deals with the specialty that includes the diagnosis and/or treatment medical, surgical, mechanical, physical, and adjunctive treatment of the diseases, injuries, and defects of the human foot.
66 ULTRASOUND - Ultrasonic waves, used in medical diagnosis and therapy.
67 DIETARY - The delivery of care pertaining to the provision of optimal nutrition and quality food service for individuals.
68 EMPLOYEE HEALTH UNIT - A prescheduled organized clinic defined to provide health care services to local facility employees usually for employment related conditions.
69 ENDOCRINOLOGY - A prescheduled organized clinic that deals with the science dealing with the internal secretions and their physiologic and pathologic relations.
70 WOMEN'S HEALTH SCREENING - A general health screening clinic for the female patient, related to female gender disease. A prescheduled organized clinic in which female gender health screening is performed for the early detection of disease or disease precursors in apparently well

female so that health care can be provided early in the course of the disease or before the disease becomes manifest.

71 COMPUTED TOMOGRAPHY

72 MAMMOGRAPHY - Examination of the breast for diagnostic purposes by means of roentgen rays, the record of the findings is impressed upon a photographic plate.

73 GENETICS - A prescheduled organized clinic that deals with the branch of science dealing with heredity.

74 SPEECH PATHOLOGY

75 UROLOGY - A prescheduled organized clinic that deals with the branch of medical science that embraces the study, diagnosis, and treatment of diseases of the genitourinary tract.

76 LABORATORY SERVICES - Pathology and clinical laboratory services. The services that provide information on diagnosis, prevention, or treatment of disease through the examination of the structural and functional changes in tissues and organs of the body that cause or are caused by disease.

77 CASE MANAGEMENT SERVICES - Case management services provided in clinics and community settings to the chronic mentally ill patients.

78 OVER THE COUNTER MEDICATIONS - An encounter that occurs for patients who receive over the counter (OTC) medications.

79 TRIAGE - A nurse visit only to determine priority of need and proper place of treatment. Usually, the patient is given an appointment to return at another date and time. If the patient is referred, from triage, to a specific clinic then the appropriate clinic code will be assigned.

80 URGENT CARE - The encounter is usually a walk-in and non-emergent in nature. A mid-level provider (CPA, FNP, etc) usually provides the care. With full nursing staff support. This service is not provided in the Emergency Room; usually another area of the facility is designated to provide urgent care. It is different from an Emergency Room encounter in that the definition for emergency room encounter "any patient that is screened, evaluated and/or treated in the Emergency Room, and the care is documented on the EVR (IHS-114) form.

81 MEN'S HEALTH SCREENING - A general health screening clinic for the male patient, related to male gender disease. A prescheduled organized clinic in which male gender health screening is performed for the early detection of disease or disease precursors in apparently well men so that health care can be provided early in the course of the disease or before the disease comes manifest.

82 DAY TREATMENT PROGRAM - A general clinic that provides major diagnostic, medical, psychiatric psycho-social and pre-vocational treatment modalities in a defined day treatment program setting.

83 LABOR AND DELIVERY - When a pregnant patient present directly to the OB Inpatient Unit for outpatient services, i.e., fetal monitoring, non-stress test, contraction stress tests, biophysical profiles, amniotic fluid assessment, and ultrasound performed by obstetrics providers as opposed to a radiology or ultrasound technician. NOTE: If the patient is subsequently admitted as an inpatient, the patient will be admitted to the OB services (08) or Nurse-Midwifery Services (22).

84 PAIN REDUCTION - A prescheduled organized clinic defined as any visit to a clinic "primarily for the purpose of" pain reduction using anesthesia or other appropriate service. This may include acupuncture or other pain reduction techniques.

85 TEEN CLINIC - A prescheduled organized clinic defined to provide medical and counseling service to adolescence, age range from 11-19.

86 TRADITIONAL MEDICINE - A setting where the traditional medicine practitioner provides their respective services.

87 OBSERVATION: An observation patient is a patient who presents with a medical condition with a significant degree of instability and patient disability who needs to be monitored, evaluated and assessed for admission to inpatient status or discharged for care in another setting. An observation patient can occupy special beds set aside for this purpose or may occupy beds in any unit in a hospital. Medicare guidelines note that this type of patient should be evaluated against inpatient standard criteria and if the patient is expected to need hospital care for more that 24 hours, then the patient should be admitted as an inpatient. If the patient meets the inpatient criteria, then the patient should be admitted. If not, then plans should be made for discharge to an appropriate setting. Inpatient status is not determined by the length of stay but by the physician's intent at the

time of admission. The length of the observation period should not be longer than approximately 36-48 hours.

88 SPORTS MEDICINE - Sports Medicine is a rapidly growing medical specialty. The American Board of Medical Specialties defines the field of sports medicine as a broad area of health care which includes: (1) exercise as and essential component of health care throughout live; (2) medical management and supervision of recreational and competitive athletes and others who exercise, and (3) exercise prevention and treatment of disease and injury.

89 EVENING - An organized evening clinic, between the hours of 5:00 p.m. to 10:00 p.m., that would normally be General (01) during the day.

90 TELE-MEDICINE - The provision of consultant services by off-site physicians to health care professionals on the scene, as by means of closed-circuit television.

91 TELE-RADIOLOGY - The provision of radiology services, diagnoses, consultation, treatment and transfer of medical data through interactive audio, video or data communications that occur in the physical presence of the patient.

92 DIALYSIS - The treatment of patients by an IHS provider at the dialysis site/room/annex.

DEVELOPING A POLICY AND PROCEDURE MANUAL FOR HEALTH PROVIDERS/PROGRAMS

Introduction

Most every professional is aware of the need for policies and procedures. However, there are many professionals that are unable to differentiate between a policy, a procedure, and a Standing Order. Also, many professionals are not certain of which items should be included in a policy and procedure manual. This brief section will present guidelines for policies and procedures and will also present a sample Table of Contents (or guidelines) on what items should be contained in a policy and procedure manual.

Polices and procedures support the goals and objectives of the organization by providing the means for accomplishing the goals and objectives of an organization. Policies and procedures clarify and standardize the discipline or program's guiding rules. Policies will answer the **why** and **what** concerning the discipline or program and its role in the organization. Generally, policies pertain more to administrative matters.
Procedures tell **how** the policies will be carried out. Generally, in the health field, procedures pertain more to clinical matters.

Standing Orders are specific treatment (usually a medication but it can be another type of therapy) to be used under specific instances. Every procedure must have a policy but not all policies have a procedure.

Every Health program or discipline faces the task of developing a policy and procedure manual (PPM). The primary purpose for developing a PPM is to enhance communication:
• with other health providers and staff,
• with other accrediting agencies and organizations,
• and, with clients and the community.

In some cases the components of a PPM may be required by state law, accreditation standards (JCAHO or AAAHC, CARF, etc.), professional practice acts, Standards of Practice from professional associations, from institutional policies, quality of care issues, program evaluation considerations and to ensure continuity of care.

POLICIES

Policies flow from planning and are a very useful connection between goals and action. With the development of clear plans, policies can be set to give useful guidelines for making decisions and implementing plans.

Policies explain how the goals of the organization will be achieved and serve as guides that define the general course and scope of activities permissible for goal accomplishment. They serve as a basis for future decisions and actions, help coordinate plans, control performance and increase consistency of action by increasing the probability that different managers will make similar decisions when independently facing similar situations. Policies also serve as a means by which authority can be delegated.

Policies can be implied or expressed. Implied policies are not directly voiced or written but is established by patterns of decisions. They may have either favorable effects or unfavorable effects and represent an interpretation of observed behavior. Express policies may be written or oral. Oral policies are more flexible than written ones and can be easily adjusted to changing circumstances. However, they are less desirable than written ones because all staff may not know them.

Policies can emerge in several ways – originated (internal), appealed, or imposed (external). The originated policies are usually developed by top management to guide subordinates in their function.

PROCEDURES

A procedure is a system that describes in detail, the process or steps taken in order to accomplish a job. Procedures supply a more specific guide to action than policy does. They emphasize detail while policies concentrate on more general principals. Procedures help achieve a high degree of regularity by

enumerating the chronological sequence or steps taken. Procedures are interdepartmental or intradepartmental and consequently do not affect the entire organization to the extent that policy statements do.

Improvement in operating procedures increases productivity. Waste in performing work can be decreased by applying work simplification that strives to make each part of a procedure productive. First one decides what work needs simplification by identifying problem areas. Next the work selected is analyzed carefully and in detail. Charts that depict the components of the work and the workflow are useful for motion or procedural analysis.

Writing procedures demands a consistent format that considers the definition; purpose; materials needed, and how to locate, requisition, and dispose of them; steps in the procedure; expected results; precautions; legal implications; and responsibilities. Each step in the procedure leading to the accomplishment of a goal should be necessary and in proper relationship to other steps. Balance between flexibility and stability should be maintained. Each procedure should be easily replaced with a revised one.

Procedures:

- Describe what, who, where, when, and why
- Define terms
- Explain how to use the procedure
- Has a header:
- Subject
- Purpose
- Scope/Staff Governed
- Effective date
- Date Reviewed/Revised
- Approved by
- Distribution
- Parts, Forms Needed
- Cautions, Notes
- Summary
- Describe the Process
- Arrange the steps in order
- Assign the actions
- Describe each step
- Establish requirements – equipment, materials and other prerequisites
    - Identify decisions and verifications
    - Note special conditions and cautions

Definition of Terms

A clear definition of terms should be included in any policy and procedure manual.

Creed - A belief or faith that lacks precision but serves as a foundation upon which policies are developed.

Law - A statement of an order that is invariable under given conditions. Laws are rigid statements providing a framework for policy promotion.

Policy - An understanding by members of a group that makes the actions of each member more predictable to other members. A policy clearly defines the range within which individual decisions can be made and encourages clear and forceful decisions. Policy can also be described a standard of practice or prudent practice; a line or course of action. Policies pertain more to administrative matters.

Practice - The usual mode of handling a given problem. A practice stresses expediency and things, as they are, a policy stresses direction and things as they should be.

Practice Guidelines - Descriptive tools or standardized specification for care of the typical patient in the typical situation, developed through a formal process that incorporates the best scientific evidence of effectiveness with expert opinion. Synonyms or near synonyms include criteria, parameters, protocol, algorithm, review criteria, preferred practice pattern, and guideline.

Practice Parameters – Strategies for patient management, developed to assist practitioners in clinical decision making. Practice parameters include standards, guidelines, and other management strategies.
Principle - A universal statement that remains true even when conflicting statements may be claimed to be valid. A principle is valid and cannot be good or bad; a policy may be good or bad; but it is valid only in the sense that someone has decided that it is to be used as a guide.
Procedure – A system that describes, in detail the steps to be taken in order to accomplish a job. Procedures emphasize details; policies concentrate on basic general principles. In the health field,
procedures pertain more to clinical matters.
Process - A goal-directed, interrelated series of actions, events, mechanisms, or steps.
Protocol -- The customs and regulations dealing with the management of certain specific situations.
Rule - A statement of precisely what is to be done (or not done) in the same way every time with no permitted deviation. Rules allow no range for decision-making; policy encourages decision-making by offering guides.
Standards - A statement of expectation that defines the structures and processes that must be substantially in place in an organization to enhance the quality of care.
Standing Order -- Specific treatment (usually a medication but can be another type of therapy) to be used under specific instances.

From these definitions it can be seen that policies and procedures are general, generic guidelines for practice, while protocols and standing orders are specific guidelines for specific instances.

Advantages and Disadvantages of Written Policies
Although the overall purpose of written PPM is communication, several advantages and disadvantages of this communication can be identified, and indicated below:

Advantages of Written Policies and Procedures:
1. They define the scope of practice for an individual, discipline or program of Health Providers.
2. They provide guidelines for new Health Providers or students.
3. They help set the standards of care for the community in which the Health facility practices.
4. They provide documentation of the role and responsibilities of Health Providers and the organization.
5. They help the Health Provider, program or organization interface between physicians, nurses, other staff, clients and the community.

Disadvantages of Written Policies and Procedures:
1. It is time-consuming to write them.
2. They must be updated as needed to reflect any changes.
3. They document what you *must do* in a given circumstance, OR
2. If you ever decide to deviate from the written policy, you must provide adequate justification and documentation in writing.
3. A PPM that is not revised regularly as your program skills and abilities increase may limit the practice of your particular health discipline and can also limit your department.

Anatomy of a PPM

The following information suggests components to be contained in a PPM. All sections may not be necessary in your manual. Policy and Procedure Manual's vary according to the Health Provider's skills and practice setting.

Title Page and Date
A title page is not essential but adds to the professional appearance of the document. Include the date each time the PPM is updated.
Introduction
The introduction contains a paragraph or two on why you are doing what you are doing. It answers such questions as: Does *the community need this Health Provider, program, and discipline? Why are you writing this document?*
Who was involved in preparing this material? Discuss any unusual or culturally relevant community needs; purposes of writing this document and who was involved.

Mission and Vision Statement of Patient Education

Philosophy of Care
The philosophy of care section contains statement(s) of your beliefs and the guiding principles that determine the practice of _____ at your facility. It should be consistent with the philosophy of pertinent health professional organizations and/or the Tribal hospital and clinics where you practice.

Key content areas include the following:
1. Beliefs/principles relating to client care such as quality, safety, awareness of consumer rights and responsibilities;
2. A framework that integrates your profession or program into one larger picture. For example, where does your _____Program fit into the community? the Clinic? the Hospital? the IHS Area Program? the national IHS Program?
3. A discussion of the professional commitments you are making regarding the "currentness" of your Program, responsibilities, competency, and accountability.

Purposes/Goals of Practice
Purposes of general goals of your program should be outlined in this section. What do you plan to do for your clients and their families? What differences can your care make? Although goals can be general, try to make some of them measurable outcomes so they can be evaluated later. Most of your purposes should be congruent with those other Health Programs but they should also reflect the unique purposes of your program based on your own unique skills, location and/or population.

Functions and Responsibilities of the Health Provider, Program or Discipline
This is one of the most critical sections of the PPM as it defines the scope of profession. Therefore, it is important to spend some time on this section and draw from examples from other well-written Policy and Procedure Manuals.

Definition of Terms
Briefly define important terms that you will use in the PPM.

Responsibilities of Clients
A section on the responsibilities of clients might be included in order to clarify your expectations of clients. This section can be used as a tool when discussing the operation of your health discipline with clients. It may list client responsibilities such as:

1. Participation in their own care by keeping appointments, listening to advice and asking questions;
2. Participation in the educational process by reading appropriate pamphlets, brochures, viewing of video's, etc.;
3. Agreeing, if necessary, to participate in evaluations;
4. Recognizing the limitations of educators and accepting physician/hospital care as needed.

WORKING OUTLINE FOR PREPARATION OF A POLICY AND PROCEDURE MANUAL

1. Title Page
2. Introduction
3. Definition of Terms
4. Mission, Vision, Philosophy of Care
5. Purpose/Goals of Practice
6. Functions and Responsibilities
7. General Functions
7. ponsibilities of Clients
9. Additional Sections (as desired) date each page
   Procedures
   Standing Orders:
   Protocols

10. Orientation Program
11. In-service Education, Continuing Education
12. Quality Assurance
13. Policies and Procedures Approved by the Governing Board, Medical Staff and Administration
14. Copies Of Current Disaster and Fire Manual
15. Infection Control
16. Safety Policies -
17. Preventive Maintenance/Electrical on any Program equipment
18. Organization Chart - Specific to the department with documented relationships to Medical Staff, if any, and Administration (direct or indirect). Dated. Narrative statement also recommended.
19. Organization chart - copy of current, dated, hospital-wide chart on file in the Policy and Procedure manual.
20. Hours of operation, weekends, after-hours, or on call-coverage method.
21. Job descriptions - for each employee, dated.
21. Record of licenses, registration numbers with dates of expiration, updated regularly and filed in Personnel according to clinic/hospital policy for ongoing verification of current licensure including any teaching or State licenses, certification, RN licensure, CPR, Red Cross, Etc.
22. Copies of respective sections of JCAHO - and other appropriate standards and regulations.

SUGGESTED ADDITIONAL CONTENTS FOR A PATIENT EDUCATION POLICY AND PROCEDURE MANUAL

Annual Patient Education Work Plan
Budget/Spending Plans for Patient Education
Clinic/Hospital Organizational Chart
Any Grant Proposals for Patient Education
Goals and Objectives Statement
Monthly Reports
Quarterly Reports
Year End Reports
Patient Right's and Responsibilities
Personnel
Quality Assurance
Position Description
Scope of Work for Patient Education
Any Strategic Planning for Patient Education
Workshops/Training/In-Service Education Doumentation

JCAHO Patient and Family Education (PFE) 2000 Standards

PF.1	The patient's learning needs, abilities, preferences, and readiness to learn are assessed.
PF.1.1	The assessment considers cultural and religious practices, emotional barriers, desire and motivation to learn, physical and cognitive limitations, language barriers, and the financial implication of care choices.
PF.1.2	When called for by the age of the patient and the length of stay, the hospital assesses and provides for patient's academic education needs.
PF.1.3	Patients are educated about the safe and effective use of medication, according to law and their needs.
PF.1.4	Patients are educated about the safe and effective use of medical equipment.
PF.1.5	Patients are educated about potential drug-food interactions, and provide counseling on nutrition and modified diets.
PF.1.6	Patient are educated about rehabilitation techniques to help them adapt or function more independently in their environment.
PF.1.7	Patients are taught that pain management is a part of treatment.*
PF.1.8	Patients are informed about access to additional resources in the community.
PF.1.9	Patients are informed about when and how to obtain and further treatment the patient may need.
PF.1.10	The hospital makes clear to patients and families what their responsibilities are regarding the patient's ongoing health care needs, and gives them the knowledge and skills they need to carry out their responsibilities.
PF.1.11	With due regard for privacy, the hospital teaches and helps patients maintain good standards for personal hygiene and grooming, including bathing, brushing teeth, caring for hair and nails, and using the toilet.
PF.2	Patient Education is interactive
PF.3	When the hospital gives discharge instructions to the patient or family, it also provides the instructions to the organization or individual responsible for the patient's continuing care.
PF.4	The Hospital plans, supports, and coordinates activities and resources for patient and family education.
PF.4.1	The hospital identifies and provides the educational resources required to achieve its educational objectives.
PF.4.2	The patient and family educational process is collaborative and interdisciplinary, as appropriate to the plan of care.

Subject: Client/Patient Satisfaction Interview/Survey

Why has customer satisfaction become so important to business in general and to health care in particular? What happens when customers (or patients) become dissatisfied? How does one prevent or remedy dissatisfaction? Patient satisfaction should be a Hospital/Clinic objective.

Dimensions of Patient Satisfaction

Although most patients are generally satisfied with their service experience, they are not uniformly satisfied with all aspects of the care they receive, and therein lie the challenge to health care management. How much service is enough to elicit high satisfaction among customers and ultimately to keep them returning to the Hospital/Clinic with satisfaction, and just what kind of service is that?

What are the dimensions of patient satisfaction? According to a national survey the ranking is as follows:

1.	Highest priority:	Overall care
2.	Second priority:	Cleanliness
3.	Third:	Physicians
4.	Fourth:	Nurses
5.	Fifth:	Other health staff
6.	Sixth:	Concern of staff
7.	Seventh:	Admissions/Discharge
8.	Eighth:	Courtesy/helpfulness of clerical/secretarial/business staff
9.	Ninth:	Parking/Convenience
10.	Tenth:	Cost of Care

Patient Satisfaction Defined

Many health providers have complained that patient satisfaction is an ill-defined concept. Perhaps, in fact, it is difficult to define or describe patient satisfaction. A simplistic version of PFCE defined is "the positive evaluation of distinct dimensions of health care. The care being evaluated might be a single clinic visit, treatment through an illness episode, a particular health care setting or plan, or the health care system in general."

There are ten constructs or elements that can be used to determine patient satisfaction:

1.	Accessibility/Convenience	6.	Humanness
2.	Availability of resources	7.	Information gathering
3.	Continuity of care	8.	Information giving
4.	Efficacy/outcomes of care.	9.	Pleasantness of surroundings
5.	Finances	10.	Quality/competence

Survey Administration

Most surveys must rely on three basic methodologies:

1. Surveys administered *in-person,*
2. Surveys conducted with individuals over the *telephone*
3. Surveys using a *mail-out* and return-response mechanism.

Survey Questions

There are four "rules" to bear in mind when developing a survey:

1.	Length of the survey:	Surveys being too long or too short
2.	Question format:	Avoiding double-barreled questions ("Did Admissions staff serve you *promptly and* courteously?)
3.	Appropriateness of Questions	Does the question ask what it was intended to ask?
4.	Follow-up Questions:	*In-Person* or *telephone* interviewers should probe with follow-up questions: "Is there anything else?" Written surveys should provide space for comments.

Research Design

1. Determining Research Objectives:

Before collecting data, it is essential that the researcher establish with management the purpose or objectives of the study. It is not uncommon for management to initiate a research project with a question as vague as "How do I know how satisfied patients are with the care we are providing?" Before attempting to answer such a question, the researcher needs to clearly understand which patients, departments, or services management wishes to study and why. It is an error to assume that one study can answer all of management's questions.

The next question to consider is what management means by patient satisfaction -- what they really want to know and why. Some managers may equate satisfaction with patient complaints, or lack thereof, believing that as complaints decrease, satisfaction increases.

2. Selecting the Methodology: Patient satisfaction research can be divided into two general categories:

A. Qualitative Methods:

Qualitative research describes both the service received and patient's experience of it. To get this information, the researcher must enter the patient's world and experience the service from the patients' perspective. To gain this perspective, the researcher immerses himself or herself in the service as if he or she were a patient. In addition to observing the service, informal and in-depth patient interviews are conducted, as well as focus groups. Clinical staff is also interviewed to gain their perspective of the patients' experience. Quite often, qualitative research is the first stage in a research project because it affords an opportunity to explore the patient's world.

Appropriate Uses for Qualitative Methods:

1. Management is unclear about what they want to know about the service, and why.
2. Management is primarily interested in obtaining information that will be helpful in understanding how to improve the service.
3. The researcher does not fully understand the service, the characteristics of the patients, or their problems, language, expectations, and needs.
4. It is unclear how to interpret quantitative patient satisfaction data.

B. Quantitative Methods:

Quantitative research measures patient satisfaction by counting or by using scales. Counts are made on the number of patients who complained, the number indicating they were satisfied, etc.

Another form of quantitative research involves the use of various types of scales on which respondents are asked to rate various service attributes on an evaluation continuum (scale):

Rate the overall care 1 2 3 4 5

Appropriate Uses for Quantitative Methods:

1. How satisfied are patients?
2. Will service changes (for example, increasing or decreasing the number of staff, facility improvements, etc.) affect patient satisfaction?
3. Are patients more or less satisfied with the Prenatal Clinic as compared to Well-Child Clinic?

ACKNOWLEDGEMENTS

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